Who is a private nursing practitioner?

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Abstract
When asked about nurses in private practice, one realises how many misconceptions exist. Very few colleagues understand who or what one is speaking about, never mind those who are not nurses. In fact, the private nurse practitioners have been asked by the statutory councils if we work for the private ambulance services. There are also many who mistakenly believe that private practitioners earn “lots of money”. Neither of these statements is accurate. This article will introduce the field of private nursing practice, dispel some myths, and explain what we do.

Introduction
The new Nursing Act (33 of 2005) speaks of Private Practice, but does not give a definition. A proposal has been made, based on the regulations for other health practitioners, which defines private practice as “the practice of a health practitioner who practises for his or her own account, either in solo practice, or as a partner in a partnership, or as an associate in an association with other practitioners, or as a director of a company providing health care”.1,2

The Constitution of the Society of Private Nursing Practitioners (SSNP) defines its members as “any self-employed registered nurse or midwife currently registered with the South African Nursing Council (SANC), operating an independent practice and practising within the scope of practice of a registered nurse or midwife”. Independent practice is defined as “the provision of nursing and related services in a setting in which the practitioner is not professionally accountable to another registered nurse or other health care practitioner registered as such with the relevant statutory council, recognising that all registered nurses and midwives remain accountable for their own acts and omissions within the scope of practice of registered nurses and/or midwives”.3

Exploring the early history of nurses in South Africa we discover that nurses and midwives in earlier years were both independent and self-employed. With the introduction of hospitals and nursing agencies, there was a move toward full employment through nursing agencies, enabling one to work autonomously outside a hospital setting. During this time, midwives continued to practice independently providing for home-based births. In the late 1950s registered nurses again started taking the plunge as independent, self-employed practitioners.

The changes to the healthcare structures in South Africa which emanated from the growth of private hospitals and medical schemes in the 1970s and 1980s necessitated the development of home-based “district nursing” services on a fee-for-service basis. These services have extended from ante- and postnatal care, midwifery, general and psychiatric services, through to wound care and palliative care. With the gradual demise of the state funded home care nursing services, there has been an increasing demand for private nursing which is not agency based, with long shifts. Other services which have traditionally been provided by the state sector are also being provided in regions where these are limited or have been withdrawn. School health nursing is an example of this. The introduction of specialised services and technology has also attracted nurses who have an entrepreneurial spirit, in areas such as sclerotherapy and providing leeches for post-operative wound care to the academic hospitals. The fields are as broad as it is possible to access appropriate training.

In addition to the traditional fields, nurses are also highly sought after by the retail pharmacy industry where they provide healthcare advice and preventive services to the general public, or in managed healthcare organisations to assist with risk assessments and health promotion. The occupational health nurse who works independently, not in a salaried position or through an agency, would also be considered to be a private practitioner.

It would therefore be appropriate to suggest that a private nurse practitioner is:
- any registered nurse who provides nursing care in the private sector in an independent position
- an independent midwife or general nurse in the community
- a general nurse/midwife in a pharmacy or doctor's rooms or
- a general nurse providing screening, care, or education in a setting other than as a paid employee.

The debate continues
It is debatable whether certain categories of employment, such as medical representatives and agency nurses could be classified as private practitioners as the service being provided does not meet the criteria of independent as described by the SPNP Constitution.5 It could also be argued that pharmacy-based nurses are fully employed, but in most instances they are not accountable to another healthcare professional except possibly in the national chain stores.

Registration as a private practitioner
At this point, there is no legal requirement to register as a private practitioner, except to maintain one’s SANC registration.

With the growth of private healthcare providers across all fields, the medical aid societies found themselves facing a challenge of identifying legitimate practitioners. The introduction of practice numbers indicating statutory council registration as well as professional group registration with the medical scheme industry association Registered Association of Medical Schemes (RAMS), and subsequently with its successor, the Board of Healthcare
Funders (BHF) led to a definition which suggests that one can only be a private practitioner if you have a number (one if its numbers), or alternatively, if you have a number you must be in private practice. This would be true if such registration were a statutory requirement, but it is not. If the patients are not going to claim fees back from their medical aid, a number is not required. At the same time, a few years ago RAMS decided that all registered nurses who were not working in a hospital needed a RAMS number. All registered nurses working for agencies were required to apply for practice numbers, but not the staff nurses or nursing assistants. This decision was subsequently reversed but not before the number of nurses supposedly in private practice, rose from around 250 to 3,000 practitioners nationally.

What makes a private practitioner?
Working as a private practitioner presents many challenges but also many rewards. If one were to make a list of the attributes a nurse practitioner requires, it would include professionalism, entrepreneurship, and the ability to work without support from others while maintaining collegial relations with other healthcare providers. One also needs a clear sense of self and an understanding of the limitations of one's skills in terms of scope of practice.

The BHF recommendations indicate that one may not charge for the services of a locum, in which case one must be prepared to be on call seven days a week, 24 hours a day. Patients do come first and family often a poor second. In a survey of private nurse practitioners in 2005, the practitioners were able to demonstrate that full-time practitioners were working at a level of 150% in some instances, which would equal about 16 hours every day.

One also requires sound financial management skills, supplemented by a support team which may include accounting and legal practitioners. It is a fallacy that private practitioners make lots of money. While expenses are never ending, ensuring a regular income which not only covers those expenses, but provides a reasonable monthly income can be stressful. Funders, such as medical schemes, do not reimburse the expenses directly to the nurse unless one charges their tariff. While the Competition Commission ruled that the BHF tariffs (Scale of Benefits) were anticompetitive, this has been circumvented by the medical schemes through the annual publication of a national health price reference list (NHRPL) by the statutory body for the medical scheme industry, the Council for Medical Schemes.

This listing effectively limits the services for which schemes will pay, as well as setting limits. Services which are not listed include HIV counselling and testing, family planning services, and various specialised services, as well as any services which are provided free by the state, such as infant immunisation. Securing payments for these is therefore a key challenge.

If one were to charge these tariffs only and see one new patient and six repeat patients a day for wound care, taking into consideration the time taken to travel between patients, a practitioner may have an income of R12,000 for the month, but profit (salary) of R3,000 after all expenses. So why do we do it?

Rewards of private practice
The growth of managed health care and changes in the private sector have left many patients and clients in a society which is technologically and financially driven. Early hospital discharge and the reduction of community home-based district services, has resulted in patients being left to fend for themselves after traumatic incidents and with chronic conditions.

If the practice has been developed using a professional approach to the financial management, in which financial terms are clearly and confidently arranged with the clients and medical schemes prior to commencing care, it is possible to earn a sustainable income.

Assisting and guiding young parents through the full cycle from conception through to post natal and well baby care, or achieving continence, or a healed pressure sore are some of the rewards. One may argue that these achievements are not unusual.

The reality is that this is nursing care at its most challenging given the environment in which it takes place, which may vary from the mansions of the wealthy to the shacks of the informal settlements. There is a continuity of care which one cannot achieve in an acute care setting. It requires interventions which often extend to the whole family, and may require the ingenuity of a survivor participant when there are no funds for equipment or dressings. It enables our clients to express their wishes and have their choices respected. It earns us respect as professionals, and provides the rewards which money cannot buy — patient satisfaction and self-worth.

Private practice provides nurses with an opportunity to provide nursing care in the way we believe it should be practiced, at the highest level possible, to meet the needs of the individual. It enables continuity of nursing care which is no longer available in healthcare settings, either due to finances or patient choice, in partnership with other healthcare providers. It is often nerve wracking and frustrating when faced with the challenges of legislation and limitations of our scope of practice. It is nursing at its best.

Society of Private Nursing Practitioners
The Society of Private Nursing Practitioners is celebrating its 25th year of existence this year. It is organised on a regional basis, with regular meetings in Durban, Cape Town and Johannesburg. The Society focuses on providing a network of support and marketing for its members, continuing education and representation at national and governmental level in all matters relating to funding, legislation and practice.

The biennial meeting and conference will be held in Johannesburg in July 2008, and is open to all members of the profession, not only members of the Society. In line with international trends, a proposal has been made to change the name of the society to the Society of Private Nurse Practitioners.

For more information on the congress contact: Veronica Charleston, 011- 791-7555 or email charlest@iafrica.com.

References

Note: It should be noted that the term independence is used in this paper to describe the degree of accountability to an employer, rather than the concept of the autonomous and responsible functioning of a nurse who is accountable for all his/her actions.

Disclaimer: This article is written independently and does not necessarily reflect the views of the Society of Private Nursing Practitioners.